**Space Inclusive - Initial Referral**

An Initial Referral is our way to gain a perspective from as many different angles as possible on what works best for the individual. Please include details relating to home life, health and wellbeing, dangers and triggers, future wants and wishes, and physical health support needs. This information will help us to ascertain the most suitable Space Inclusive site for your individual and their specific support requirements.

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| **Referrer Details** |
| Referring organisation: |  |
| Name of referrer: |  | Date of referral: |  |
| Referrer contact details: |  |
| **Client Details** |
| Name: |  | D.O.B: |  | Gender: |  |
| Address: |  |
| Contact Numbers: | Home: | Mobile: |
| Parent/carer/otheradvocate name(s): |  |
| Parent/carer/advocate contact details): |  |
| Current placement, if so, where: |  |
| Days preferred/required(Please circle) | MONDAY | TUESDAY | WEDNESDAY | THURSDAY | FRIDAY | Total No. ofDays: ……. |
| Setting preferred/required(Please circle) | \*Space Inclusive | Community Outreach |
| ***\*We will contact you following assessment of this form to arrange an initial viewing.*** |
| If Community Outreach selected, please detail number of hours required & preferred times: |  |
| Funding Source | NottinghamCity | NottinghamshireCounty | DerbyshireCounty |
| [ ]  Direct Payment[ ]  Portal[ ]  Self-funding | [ ]  Direct Payment[ ]  Portal[ ]  Self-funding  | [ ]  Direct Payment[ ]  Portal [ ]  Self-funding |
| Diagnosis details: |  |
| Medical Information: |  |
| **Consent and Mental Capacity** |
| Does the person have capacity to make a decision regarding attending/ being supported by Space Inclusive? |   |
| If the person is unable to consent to attending/ being supported by Space Inclusive, is there evidence of consultation in making a best interest decision? |   |
| Have the views of people engaged in caring for the individual e.g. family, carers, CLDT been sought? Please record the names and views of those consulted. |
| **Communication** |
| Communication issues: |  |
| Communication methods currently used e.g. BSL, Makaton: |  |
| Behaviour triggers around communication |  |
| Support Requirements |
| Communication needs*Please tick all that apply* | Makaton | [ ]   |
| EAL (English as Additional Language) | [ ]   |
| Visual Timetable preferred | [ ]   |
| British Sign Language (BSL) | [ ]   |
| Visual Impairment – if so please specify needs | [ ]   |
| Hearing Impairment – if so please specify needs | [ ]   |
| Personal Care needs | Is personal care required? | Yes [ ]  No [ ]   |
| If yes, is a particular member of staff preferred? | Male [ ]  Female [ ]  Either [ ]  |
| Travel | Can the client travel independently? | Yes [ ]  No [ ]   |
| Does the client have a bus pass? | Yes [ ]  No [ ]   |
| If yes, does it include a companion pass? | Yes [ ]  No [ ]   |
| Has the client participated in travel training before? | Yes [ ]  No [ ]   |
| Behaviours of Concern*Please give details of any behaviours of concern(including triggers and strategies/techniques for managing the behaviour)* |  |
| Health and Fitness | Does the client have mobility issues? | Yes [ ]  No [ ]   |
| If yes, does the client require the use of a mobility aid? ie, wheelchair, rotunda, walker, cane, please give details: |
| Does the client have any physical impairments which may affect their ability to participate in health and fitness related activities? i.e. muscular skeletal conditions which affect joints, bones, and muscles i.e. arthritis, osteoporosis, please give details: |
| Other Support Needs |  |
| Please specify below which **skills and areas of development** the client might be interested in exploring further as part of their person-centred support. |
| **Additional Information** |
| ***IMPORTANT***: **Please attach current/last EHCP, current/last Care Plan, any current/last professional medical assessments or reports.** **Please indicate by marking the box X :****Documents Attached** [ ] **No Further Documents** [ ]  |